

<b>Case Number:</b>	CM13-0039841		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	02/03/2011
<b>Decision Date:</b>	07/07/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 52-year-old female who reported an injury on 02/03/2011 due to cumulative trauma. An MRI of the right elbow performed on 03/18/2011 revealed mild effusion. An MRI of the right shoulder dated 07/17/2012 revealed acromioclavicular degeneration and impingement, and humeral head cyst and tendonitis of the biceps tendon. The clinical note dated 10/07/2013 noted that the injured worker presented with frequent pain in the right shoulder rated 5/10 to 8/10 and weakness of the right upper extremity. Upon exam, the range of motion values of the right shoulder demonstrated 170 degrees of flexion and 120 degrees of abduction. The diagnoses included right shoulder pain and impingement, right elbow pain, lateral epicondylitis, radial tunnel syndrome, right index and middle finger pain, gastritis due to medication, a history of lupus erythematosus, and a history of fibromyalgia. Prior treatment included cortisone injections and medication. The provider recommended Ambien 5 mg, a transdermal cream 240 mg, physical therapy, and extracorporeal shockwave therapy. The provider's rationale was not included. The request for authorization form was not included in the medical documents submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Ambien 5mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),

Treatment in Workers Compensation, 2012 (web) ([www.odgtreatment.com](http://www.odgtreatment.com)), Work Loss Data Institute ([www.worklossdata.com](http://www.worklossdata.com)) (updated 02/14/2012).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Zolpidem.

**Decision rationale:** Ambien is the brand name of Zolpidem. The Official Disability Guidelines state that zolpidem is a short-acting non-benzodiazepine hypnotic, which is approved for short term use, usually two to six (2 to 6) weeks, for the treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often hard to obtain. Various medications may improve short term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists, if ever, rarely recommend them for long term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. Cognitive behavioral therapy should be an important part of an insomnia treatment plan. The injured worker has been prescribed Ambien since at least 05/2013. The efficacy of the medication was not provided. It was not indicated whether the injured worker was having trouble with sleep initiation, sleep maintenance, or early awakening. There is a lack of documentation in relation to the severity of the insomnia for use of Ambien. As such, the request is not medically necessary.

**TD cream 240mg #20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The Chronic Pain Guidelines indicate that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The provider's request for a transdermal cream does not specify the compounds which make up the medication. The provider's request does not indicate the site at which the cream was intended for. As the components of the medication are not provided, the medical necessity of the medication cannot be established. As such, the request is not medically necessary.

**Physical therapy (unspecified frequency and duration) QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement measures; Physical Medicine Page(s): 48; and 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The Chronic Pain Guidelines indicate that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The Guidelines recommend up to ten (10) visits of physical therapy over four (4) weeks. There is a lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of the prior therapy. The amount of physical therapy visits that have already been completed is not provided. The provider's request did not indicate the site that the therapy was intended for, or the specified frequency, duration, and total number of sessions of therapy being requested. As such, the request is not medically necessary.

**Extracorporeal shockwave therapy (ESWT) (unspecified frequency/duration) QTY: 1.00:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation, 2012 (web) ([www.odgtreatment.com](http://www.odgtreatment.com)), Work Loss Data Institute ([www.worklossdata.com](http://www.worklossdata.com)) (updated 02/14/2012), Criteria for the use of Extracorporeal Shock Wave Therapy (ESWT).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 201-205.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that some medium quality evidence support manual physical therapy, ultrasound, and high energy extracorporeal shockwave therapy (ESWT) for calcifying tendonitis of the shoulder. Initial use of less invasive techniques provides an opportunity for the clinician to monitor progress before referral to a specialist. There is lack of evidence in the documentation provided that would facilitate the need for the injured worker to have ESWT. There is a lack of documentation of other treatments the injured worker underwent previously and the efficacy of the prior treatments. The provider's request did not indicate the site at which the ESWT was intended for, and the frequency and duration of this treatment were not provided. As such, the request is not medically necessary.